IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

February 3, 2010

Rene Stephens, Administrator
Bitterroot Home
1411 Falls Avenue East, Suite 703
Twin Falls, Idaho 83301

RE: Bitterroot Home, Provider #13G022

Dear Ms. Stephens:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Bitterroot Home, on January 26, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance

within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 16, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

TOM MROZ, CFI-II
Health Facility Surveyor
Fire Life Safety & Construction Program

TM/lj

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G022	A. BUILDING 02 - ENTIRE BUILDING B. WING _____	01/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a residential single story, Type V(000) building. It was built in 1992 and is fully sprinklered in living spaces and closets. There is a complete fire alarm/smoke detection system. Currently the facility is licensed for 6 ICF/MR beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on January 26, 2010., under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability and 42 CFR 483.470 (j). The Survey was conducted by: Tom Mroz CFI-II Health Facility Surveyor Facility Fire/Life Safety and Construction Program	K 000		
K0152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities:	K0152		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Irene Stephens	Administration	2/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G022	A. BUILDING 02 - ENTIRE BUILDING B. WING _____	01/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0152	Continued From page 1 (iii) File a report and evaluation on each drill; (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. This STANDARD is not met as evidenced by: Based on record review, the facility failed to document fire drills were being performed once per shift per quarter. The deficient practice would affect all staff and all residents within the facility. The facility has the capacity for 6 licensed beds with a census of 5 on the day of the survey. Findings include: During record review of the facility fire drill records on January 26, 2010 at 10:25 A.M., the facility was unable to provide documentation of the fire drill for the 1st quarter nocturnal shift in 2009. The finding was acknowledged by the Administrator at the exit interview on January 26, 2010 .	K0152	K0152-This facility has experienced a change of leadership and the evacuation drill was missed in the transition. A new tickler system has been devised that is not attached to the individual manager's mail file and will now go out to the CCC Supervisor group, which includes the Quality Assurance Manager, Administrator and QMRP. This change was implemented 2/15/10.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G022	A. BUILDING 02 B. WING _____	01/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT GROUP HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Inital Comments The facility is a residential single story, Type V(000) building. It was built in 1992 and is fully sprinklered in living spaces and closets. There is a complete fire alarm/smoke detection system. Currently the facility is licensed for 6 ICF/MR beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on January 26, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability, 42 CFR 483.470 (j) and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF-MR). The Survey was conducted by: Tom Mroz CFI- II Health Facility Surveyor Facility Fire/Life Safety and Construction Program	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal CMS K tag K152, evacuation drills.	MM309	See K0152	
MM327	16.03.11.110.02(h) Emergency Electrical Service Each facility must provide emergency electrical	MM327		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rene L Stephens — TITLE: Administration — (X6) DATE: 2/26/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G022	A. BUILDING 02 B. WING _____	01/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT GROUP HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM327	Continued From Page 1 service for at least the exit passageway lighting, hall lighting, and the fire alarm system. This Rule is not met as evidenced by: Based on observation the facility failed to ensure the emergency lighting equipment operated. All residents and staff would be affected by the deficient practice. The facility has the capacity for 6 beds and at the time of the survey the census was 5. Findings include: Observation on January 26, 2010 at 1:38 P.M., the emergency lighting equipment located in the hall failed to operate in the event of failure of normal lighting. The finding was acknowledged by the Administrator at the exit interview on January 26, 2010.	MM327	MM327 – This item is on our monthly building inspection. The emergency light had been just tested on 1/18/10 and was working properly at that time. We will continue to test emergency lighting monthly and include random testing as well. This tickler system was implemented 2/15/10 by the Administrator.	